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AUTHOR Alexander, James F.; And Others
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ABSTRACT

This paper reviews the major elements of the functional family therapy model, i.e., the conceptual underpinnings, empirical foundations, treatment goals, and technology. Topics addressed include: (1) the assumption that deviant behavior is an influence strategy not acceptable to others; (2) the use of intervention strategies; (3) the role of the family therapist; (4) the goal of therapy as attempting to change specific ways in which individuals interact in interpersonal functions; and (5) the use of assessment, therapy, and education in the model. The current status and future directions of the model are discussed in terms of long-term relationship analysis, expansion to include extra-familial relationships, and the service delivery process. (Author/HLM)

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Functional Family Therapy

James F. Alexander, Leonard J. Haas,

Nanci C. Klein, and Janet R. Warburton

University of Utah

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Functional Family Therapy

The Functional Family Therapy model, as it has evolved to its current state, offers a set of specific and coherent intervention strategies derived from the integration of several diverse theoretical approaches. The present paper reviews the major elements of the model, including the conceptual underpinnings and empirical foundations, as well as treatment goals and technology. Highlighted in the following overview are several research articles (Alexander, 1973; Alexander, Barton, Schiavo, & Parsons, 1976; Alexander & Parsons, 1973; Barton & Alexander, 1977; Klein, Alexander, & Parsons, 1977; and Parsons & Alexander, 1973) and review articles (Alexander & Barton, 1980; Barton & Alexander, 1980; and Klein, Barton, & Alexander, 1980) that have focused primarily on the adolescent-delinquent family. Although this consistency in population sample has been efficacious for research and descriptive purposes, it does not generally reflect the wide applicability of the model to other family forms, such as marital dyads or families with younger children. While the principles and procedures described below are not restricted to the adolescent-delinquent family, conceptual and technical modifications necessary for treating marital dyads or families with younger children are beyond the scope of this paper. Thus the adolescent-delinquent family as a context for illustrating the Functional Family Therapy model will constitute the major focus of the paper.

Conceptual Underpinnings

Assumptions about the Meaning and Dynamics of Behavior

The Functional Family Therapy model derives the majority of its basic

principles from systems (communication, interactional) theory and social learning theory. Shared by both of these orientations is a focus on observable patterns of interaction and cognitively-mediated behavior. With respect to treating dysfunctional families, the model holds that:

(1) The major dynamic, or "reinforcer", of characteristic social behavior or interaction patterns is social influence.

(2) Strategies, that is the specific behavioral means through which family members attempt to create social influence, take their particular form as a function of learning histories and current environmental contexts.

(3) Influence attempts represent reciprocal or two-way, mutually-causal phenomena that simultaneously occur between two or more individuals. As A attempts to influence B, B is simultaneously attempting to influence A.

(4) Dysfunction or "problems" occur in relationships when the influence strategies are incompatible or unacceptable to one or more members of the group.

(5) The interpersonal functions or payoffs ("reinforcers" in very broad terms) of interactive sequences are defined both by the antecedent-response-consequence chains and longer-term relational outcomes. The latter are often not evident from an observation of immediate interactive sequences.

(6) Family members exist in polyadic systems, not just collections of dyads. The existence of polyadic relationships allows for the formation of coalitions to achieve social influence and relational payoffs. The notion of polyadic relationships also creates a situation in which relational payoffs can (and do) occur in relationships different from the one which is the focus of observation.

(7) Like the grammar of a language, the "deep structure" of interpersonal sequences may be unknown to the participants in interaction. Family members

learn interpersonal influence strategies in much the same way they learn their natural language. One can learn to speak more or less correctly without ever being "aware" of the rules of language, or the names of grammatical structures. The family therapist thus faces difficulties in the assessment process since family members are often unaware of the nature of their relationships and influence strategies and often misrepresent "truth" as they see it.

(9) Events in a family are responded to in relation to members' attributions about their meanings. These attributions powerfully affect subsequent behavior.

(10) Family therapists, particularly those treating delinquent populations, face an "affect-attributional context" characterized oftentimes by blaming, resentment, accusations of malevolent motives, distrust, hopelessness, and/or competitiveness between family members. The presence of such affects and attributions tend to engender a context antagonistic to the adoption of positive change techniques.

The concept of social influence, central to the Functional Family Therapy model in the terms described above, also occupies a central conceptual position in both systems and behavioral approaches. According to the systems framework, social influence is the major dynamic of human behavior (Haley, 1963; Watzlawick, Beavin, & Jackson, 1967). In behavioral terminology, social influence is the major secondary reinforcer, and the acquisition of social influence becomes the paradigm for human relationships from the very outset of existence. Newborn children must depend on significant others to mediate their attainment of basic primary reinforcers, since they are unable even to perform such basic survival operations as feeding and clothing themselves. Thus with certain biological predispositions, infants begin to develop interpersonal strategies through which they can influence others. One vehicle of such influence

is the process of coercion, i.e., crying, that forces others (particularly parents) into action. When the adult responds, she or he is reinforced by the cessation of crying (see Patterson & Reid, 1970, for an extended description of the coercion hypothesis). An alternative highly successful strategy for influencing others is represented in positive affectional and dependent behaviors, such as cooing and simply "being cute." In situations in which significant adults respond to and reinforce such behaviors, an interdependent system develops. As the child matures, the environment often demands alternative strategies, such as reasoning, rudiments of independent problem-solving, and the like. As such alternatives develop, the earlier modes of influence which are no longer age-appropriate are no longer reinforced, and are thereby extinguished. Behavioral problems occur when the environment demands influence strategies which are beyond the capability of the child, or when the environment fails to create a context in which new age-appropriate strategies can be learned and maintained.

Thus the influence process is not simply a one-way cause-effect phenomenon. While the child is developing social control strategies, he or she is interacting with one or more adults who are similarly attempting to develop control strategies vis-a-vis the child. When the respective strategies of child and adult are incompatible, relational crises result (Morton, Alexander, & Altman, 1976). One example is represented in the case of a child's influence attempts which tend to elicit (or require) a high degree of parental responsivity, which is incompatible with a mother's or father's strategy of reducing interaction by being "too busy, too tired," etc. Such periods of incompatibility can produce escalations of influence attempts, including unacceptable or maladaptive behaviors ("symptoms") as in the case of phobias which coerce parental reassurance, tantrums which coerce parental

"giving in," or on a parent's part, abuse or active withdrawal. At such times referrals are often made.

In the case of juvenile delinquency, the Functional Family Therapy model assumes that while social-cultural as well as developmental (physical, cognitive, etc.) demands have both allowed for and forced new control strategies on the part of the adolescent, parents have not had the desire or they have not possessed the skill to change their influence styles in ways which allow them to attain a mutually acceptable reciprocal system of influence. Adolescent crises represent an inevitable change on the part of the adolescent which has not been responded to with an appropriate change in the parents. Delinquency occurs when this leads to either or both: (1) intrafamilial problems, such as runaway, ungovernable, or violence, which represent unacceptable influence strategies; or (2) extrafamilial problems, such as adolescent influence styles expressed through truancy, violence, stealing, or prostitution. Thus in the Functional Family Therapy model, a phenomenon such as drug abuse is not seen as an intra-individual process (e.g., getting high in order to reduce anxiety) as much as it is seen as a relationship influence strategy to create or increase peer group status and/or create distance from parents. As such, it must be treated in light of these interpersonal functions.

To summarize, according to the Functional Family Therapy model, maladaptive behavior or "symptoms" are seen as influence strategies which are not acceptable to others. Though the behaviors are clearly elicited and maintained by the environment, they are not deemed as acceptable by this very same environment. Notice, however, that deviant behaviors are not seen in the FFT model as a passive response to environmental control. Rather, they represent an interaction of incompatible control attempts on the part of the adolescent and others in the environment.

One of the greatest problems facing family clinicians, researchers, and theorists is the fact that relationships, as seen in this light, cannot be conceptualized in the traditional unidirectional cause-effect paradigm that is traditional in psychology. At a basic level, "independent" and "dependent" variables become more difficult to conceptualize, since the locus of control is seen as coming neither exclusively from within an individual, nor exclusively from the environment. Instead, both operate on the other, and the identification of starting points and end results is difficult and often arbitrary. Added to this difficulty is the fact that in any given dyadic interactive sequence, the "dynamics" or locus of control may exist in large part outside of that interaction. To cite but one "clinical" example, in many homes the following sequence is observed: Father "gives in" to daughter in a conflict resolution situation, such as staying out beyond curfew with friends. Though this pleases daughter, mother becomes quite annoyed and severely criticizes father, demanding that in the future he not give in. In the next father-daughter conflict resolution interaction, father refuses to give in, citing a number of reasons (but not the fact that he is refusing to give in because his wife demanded it). This interaction perhaps makes mother happy, but leaves daughter annoyed and in fact can precipitate such behaviors as running away, becoming sullen and hostile, etc. In this vignette, the initial father-daughter interaction could potentially describe the "dynamics" of the situation, i.e. father's "giving in" both reinforced daughter, and in turn reinforced him since the giving in precipitated the cessation of arguing and led to more rewarding behaviors. In strictly behavioral terms, the second sequence was less understandable in its reinforcement value, since father's behavior was heavily influenced by mother, though she was not even present.

The Context of Intervention

According to the FFT model, the task of the family therapist is to evaluate

both the immediate sequential family interactions and the longer-term functional outcomes for family members. Moment-to-moment analyses of interactions often cannot tell the therapist the nature of functional outcomes. However, in order to ultimately change dysfunctional influence strategies, it is necessary to understand the relational end points created by the specific interactive sequences.

The family therapist's task in assessment is made even more difficult by two additional characteristics of family members seen in therapy. On the one hand, family members misrepresent their feelings, behaviors, and attributions as they see and report them. For example, fathers who come home late from work rarely attribute their lateness to an extra-marital affair or a priority of drinking with the boys. Rather, they complain that their work makes heavy demands on them. Of course, many fathers really are just plain overworked, but how is the therapist to know? In a similar vein, delinquent daughters rarely suggest they start arguments in order to be "thrown out" of the house as an excuse for sleeping at their boyfriend's house. Instead, they complain that their parents are "always on my case," etc., etc. In cases of incest, the parents rarely spontaneously offer the information that such behavior is occurring, just as delinquents rarely spontaneously accurately describe all of their behavior both in the home and outside.

Often, too, family members simply are not aware of the nature of their relationships, and the influence strategies they have adopted. According to the FFT model, as pointed out earlier, family members learn interpersonal influence strategies in much the same way as they learn language; one can learn to speak correctly without ever being "aware" of language rules or grammatical structure names. Thus while sometimes when a family member responds "I don't know" to a question about what happened, or why they

behaved in a certain way, they might be lying. Sometimes, however, they in fact are not aware.

Coupled with these complicating factors is the "affect-attributional" context that is generally present when families of delinquents initiate treatment. Again, as described initially, blaming, resentment, accusations of malevolent motives, distrust, hopelessness, and competitiveness are representative labels describing the relationships between family members. The presence of such affects and attributions tend to engender passivity, resistance, and failure to engage in positive change techniques. While systems and behavioral models have developed elegant conceptual frameworks for understanding how such families have developed, and how they need to change, neither literature has done an adequate job of describing the nature of these affective and attributional processes, and how formal therapeutic operations are implemented to reverse their negative impact.

Empirical and Philosophical Foundations

The Functional Family Therapy approach is based on a matching-to-sample philosophy. Adopting this philosophy involved the identification and operationalization of variables in normative samples which were theoretically and empirically assumed to maintain (if not create) adaptive family functioning in the face of developmental demands being placed on the family as a function of maturation. In other words, adaptive (or nondelinquent) and delinquent families were studied, and found to differ on various aspects of content-free communication process (e.g., silence, and various measures of distribution of talk, Parsons & Alexander, 1973), content and function-based measures of communication (e.g., defensiveness, supportiveness, and their reciprocity, Alexander, 1973) and, of course, family adaptiveness (e.g., delinquency).

These variables became the target of a treatment program which was

designed to impact primary, secondary and tertiary levels of delinquency prevention with 13 to 17 year old delinquents (Klein, Barton, & Alexander, 1980). Using random assignment to Functional Family Therapy, no treatment controls, and two alternative treatments, the project demonstrated that the Functional Family Therapy model directly reduced maladaptive delinquency-producing interaction patterns (Parsons & Alexander, 1973), reduced delinquency at a one-year follow-up period by 50% to 67% (Alexander & Parsons, 1973), and reduced subsequent sibling delinquency at a three-year follow-up by 50% to 67% (Klein, Alexander, & Parsons, 1977). Subsequent research and replications have demonstrated similar effects (Alexander, Barton, Schiavo, & Parsons, 1976), including the superiority of Functional Family Therapy over individually-oriented behavior therapy with a similar population, and the extension of the model to a more seriously delinquent population that had been incarcerated prior to treatment (manuscript in preparation).

The research history of the Functional Family Therapy model demonstrates that one major philosophical foundation of the model is a committment to empirical support, involving: (1) pre-intervention study of maladaptive and adaptive families to empirically (rather than intuitively or theoretically) identify relevant process and outcome variables; (2) the development of the intervention model coupled with careful process, outcome, and follow-up research to establish therapeutic impact, comparative efficacy, as well as provide a basis for subsequent component analysis and model improvement; and (3) replication of program effectiveness.

Because the model continues to undergo empirical scrutiny, the subsequent discussion of Functional Family Therapy should be considered as representing an "evolutionary slice," rather than a description of a static model. While the majority of elements had been already developed in response to the first matching-to-sample study (Alexander, 1973), subsequent research has provided

for the development of more complete conceptual underpinnings, a more careful description and better understanding of the components of intervention, as well as several important modifications in specific aspects of intervention, such as the training and interactive behaviors of effective Functional Family Therapy therapists (Alexander, Barton, Schiavo, and Parsons, 1976).

While the first major philosophical foundation of the model is a committment to empirical support, the second major philosophical underpinning of the model is represented by the matching-to-sample philosophy. The targets of change, as well as the criteria for "cure" are not rooted in theoretical or moralistic "ideals." Instead, the goal of intervention is to empirically identify the aspects of family functioning that differentially create adaptive vs. maladaptive outcomes, then to develop intervention techniques that will facilitate the changes in maladaptive families that will cause them to match adaptive families. Since the research has shown that adaptive and maladaptive families differ in each of the areas of specific interactive sequences, affective reactions, and attributional processes, each of these realms has been targeted in the intervention process.

Major Therapeutic Elements

Family therapy represents a multi-level assessment and change problem for the therapist. Not only does the therapist face the problems already described, but she or he must also consider how to become an influential agent of change. As any classroom teacher or tennis instructor knows, one cannot simply tell people how things should be done and get results. Rather, a broad body of techniques must be developed, coupled with specific interpersonal styles, for the therapist to effectively change family behavior.

Goals of Functional Family Therapy

At a basic level, the goal of FFT involves the mutual acceptance of

influence strategies, both within the family context, and between given family members and their external environments (i.e., schools, employment, etc.). This goal is met essentially in a two-stage sequence, which involves first changing the definitions, or attributional labels, held by the family about themselves and others, then secondly changing specific components of interactive behavior.

A major point of distinction between FFT and many other intervention models is that FFT avoids attempting to change the interpersonal functions, or relational outcomes, that are characteristic of interacting systems. Rather, the FFT model attempts to change the specific ways in which people attain these outcomes. Traditional psychotherapies generally attempt to "change people." For example, a patient who characteristically created interpersonal distance (e.g., by behaving in a rigid manner, being hostile, etc.) would traditionally be seen as requiring the kind of personality change or intrapsychic conflict resolution such that the person no longer "needed" distance. Functional Family Therapy, in contrast, attempts to help people develop alternative productive and rewarding behavioral strategies for attaining their functions. As mentioned above, taking a second job, or working after school, provide vehicles for distance, but of a form that is often considerably more acceptable (and rewarded) to others in the environment. Writing notes and letters on a daily basis, which has in fact become a popular technique in current marriage enrichment programs, also provides for a very pleasant form of distance. That is, the letter writer does not need to deal with the intensity of a face-to-face interaction. For those who feel the need for privacy and control, this allows the writer to pace ideas and express thoughts and feelings in ways that are comfortable. The added relational benefit of this form of distancing is that it can be highly valued by the letter recipient, who, despite the lack of face-to-face contact can receive

information, receive messages of caring, etc.

Naturally, developing alternative behavioral strategies for attaining interpersonal functions is often a difficult and complex task. The task becomes easier to the extent that therapists can separate functions from the way people attain them. Intimacy and closeness, for example, as a functional payoff can be confused with pathology if it takes the form of "smothering," mind-reading, and similar behaviors. However, if the therapist can accept the function of intimacy as legitimate, and recognize that different behavioral strategies for attaining it can be considerably more productive, then the change process becomes easier. This aspect of FFT is particularly noteworthy because it translates into very wide applicability, and relatively short treatment durations. The rapidity of change accrues from the fact that it is easier to change specific behavioral styles than it is to change the "underlying need structure" or interpersonal payoffs for people. Intimacy, attention, and nurturance are not "inherently bad" functions. Relationships only become problematic when such functions are created through such unacceptable behavioral strategies as temper tantrums, suicide attempts, and psychophysiological disorders. In a similar way, distance and less intense psychological intimacy are also not inherently bad. But when they take the form of alcohol or drug abuse, running away, and constant fighting, they create severe relationship difficulties. Instead, when they take the form of double-dating (notice the presence of another couple reduces psychological intensity) or "each family member doing their own cleaning tasks" (i.e., working on separate projects, thus interacting at low rates but nevertheless participating in a common experience), they can facilitate adaptive relationships. Thus in many ways, FFT is an appropriate target for the old psychoanalytic criticism of behavior therapy. The therapeutic changes <u>are</u> in fact relatively "superficial,"

and as a result are relatively easily accomplished. However, rather than accepting this as a criticism, the FFT model argues that it is a humane and broadly applicable philosophy underlying intervention which has received considerable empirical support.

Techniques of Change

Space does not permit an extended discussion of the techniques and conceptual manipulations that therapists must undertake to develop alternative behavioral strategies for interpersonal functions. However, even when the therapist is capable of deciding upon a more adaptive pattern of interactive behaviors within the family, there still exists the problem of instituting these changes in the family. When working with parents of younger children, or delinquents in a highly structured institutional environment, the problem of client participation is not particularly critical, since other people (i.e., parents and institutional personnel) have the ability to control such large aspects of the client's life. With adolescents, however, particularly those who have developed "delinquent" influence strategies, client cooperation becomes an essential critical variable. As mentioned above, this is often most difficult since both the delinquents and their parents tend to be characterized by hostility, passivity, and the like.

The change process therefore involves three phases, two of which are so intertwined as to be indistinguishable. These intertwined phases are assessment and therapy, which are formed simultaneously, and both are followed by the third phase of education. According to the FFT model, it is only through education, i.e., specific changes in behaviors that are reinforced by the environment, that long-term positive change will be maintained. Unfortunately, education cannot occur in a vacuum. Instead, the assessment process is necessary to identify not only the specific problematic interactive sequences,

but the interpersonal functions that are being met by these sequences. No matter how noble, a change program that, for example, requires intensive monitoring of a child by father will fail if father's interpersonal function is distance from the child. The now painfully repeated history of failure of generalization of treatment effects to the natural environment supports the importance of developing change programs that not only will demonstrate immediate positive effects, but will also be maintained. For this reason, the therapy phase is also essential, since with the majority of delinquent families it is necessary to considerably change the negative "affect-attributional" context that the family experiences. The following outline, taken from Manchester and Meiers (Unpublished manuscript, 1980), provides a very brief overview of these three major phases of intervention:

A. Assessment: done in the here-and-now, simultaneous with intervention
   1. Identify functions of behavior for each family member
   2. Enter the system in a way which establishes rapport and provides information
      a. by exploring behavior sequences (What happens?)
      b. by exploring feelings and cognitions (How do you feel? What do you assume this means?)
      c. by exploring the process of relating in the session itself (How do family members interact with one another?)

B. Therapy: to modify the cognitive sets, attitudes, expectations, labels, affective reactions and assumptions of the family; to bring all members to the point where they want to change and can benefit from education
   1. Establish a relational focus
      a. through questions (What do you do, father, when mother cries?)
      b. through comments
      c. through inter-relating feelings, thoughts, behavior
      d. through interpretations

e. through identifying behavior sequences

f. by using the therapist as a direct tool (explicitly referring to own relationship to family; implicitly using humor, nonverbal cuing, accentuating mood or behaviors

g. through blocking interactions that are negative or initiating positive interactions

2. Establish new interpretations and meanings of behavior

a. Non-blaming: casting members in more benign light

b. Relabeling: (e.g. the constant interruptions of mom are relabeled as protective instead of as intruding)

c. Discuss the implications of symptom removal (What would happen to this family if Billy were no longer a problem?)

d. Exaggerate the symptom; make more of it or less of it

e. Shift the focus from one problem to another

3. Resistance indicates that one or more members cannot see how change will benefit them; more relabeling and relational focus

C. Education: To teach specific skills so that positive change can be maintained; the techniques of how to change once the family has accepted the relabeling of the "Problem"

1. Communication skills training (e.g. contingency contracting, negotiation skills, active listening; during sessions, model and shape communications to increase the brevity of communications, increase the directness, congruence, behavioral specificity, and the taking of responsibility for one's own feelings, needs, etc.

2. Technical aids (e.g. token and point systems, charts and graphs, "the Saturday box", the three bell system, time out, note and message centers, school-home feedback systems, relaxation

3. Interpersonal tasks (e.g. conflict management practice such as Bach's fair fighting, family outings and projects, couple exercises, allowing transitional times, competency builders)
4. Things to consider when planning any educational task:
   a. Does the task provide immediate relief or pleasure for each person involved?
   b. Does everyone see it as do-able and of mutual benefit?
   c. Can everyone explain the assignment to you?
   d. Is it simple enough to ensure success?
   e. Will everyone be interested in how others do?

Current Status and Future Directions

One of the most immediate problems facing the Functional Family Therapy model as currently developed is the nature of "meaning" units. As mentioned above, momemt-to-moment interactive sequences provide some information regarding the nature of relationships, but cannot contain all the data necessary. Unfortunately, a conceptual framework for understanding longer-term relational outcomes has not been well-developed. As a result, the relationship between moment-to-moment interactions and longer-term relational outcomes is unclear. As a result, both in the clinical and research realms these important aspects of behavior remain much more in the relam of intuition.

The FFT model must also be expanded to formally include other aspects of relationships, particularly extra-familial and service delivery relationships. Treatment programs already developed include careful attention to extra-familial factors, such as developing relationships, educational and employment systems, developing or improving peer relationships, dealing with social and cultural factors, and the like. Yet while these operations constitute an important component of the larger intervention program, they are not carefully formalized in the model itself.

The service delivery process is also one that receives a great deal of attention in family therapy programs, but has not been well conceptualized or researched. The impact, importance, and considerations relevant to "untrainable" therapist characteristics, such as gender, ethnicity, and age are often commented upon in clinical settings, but rarely appear as formal components of intervention models or research programs. In a similar way, experienced clinicians learn "tricks of the trade" in terms of dealing with non-motivated clients, different value systems (i.e. different cultural, religious, and ethnic groups), as well as different family structures such as single-parent families or reconstituted families. Such "real world" aspects of technical application, however, tend to remain in the literature as a growing body of folklore, rather than feeding back into the basic theoretical models and conceptual systems that underly the treatment programs.

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